INVOICE FOR STATE OF WYOMING RESPITE PROGRAM

Provider: Provider SS#			Phone:	
Provider Address:		City	State Zip	
Child's Name:Chil		ild's SS#		_Allowed hours for month
Date of Service	Time In use A.M. or P.M.	Time Out use A.M. or P.M.	Hours Served	
				_
				_ _ _
	5			
				Total Hours Served
Parent Co-Pay per hour: \$ X Total Hours Served: = \$				(Collected by Respite Provider)
DDD Rate of Pay (\$8.00	Parent Co-Pay): \$	X Total Hour	s Served:	_ = (Paid by BHD)
certify under penalty of	perjury that the above	is true and accurate to	the best of my kno	owledge.
Signed: Provider's Signat	ure	Date:		
Signed: Parent's Signature		Date: _		
Mail or Fax to:				

Behavioral Health Division State Respite Coordinator - Linda Trujillo 6101 Yellowstone Road Ste 259A Cheyenne, WY 82002

307-777-7684 | Fax: (307) 777-6047

Note: If additional lines for Dates of Service are needed, please write "continued" in the Total Hours Served box and submit a second form. Total all hours from both forms on the second form.